Ohio Medicaid Health Home Program

HEALTH HOME
INFORMATIONAL FORUM
WRAP-UP WEBINAR

JUNE 22, 2012
9:00 AM – 10:30 AM
HEALTH HOME INFORMATIONAL WRAP-UP WEBINAR AGENDA

• Target Population
• Interface between health home and other services and programs
• Billing & Reimbursement
• Regions
• General Updates
• Next Steps
Q & A: Target Population
Providers must have the capacity to serve existing clients with SPMI and be able to accept new referrals

- The Ohio health home model does not include a pilot or phase-in period at the provider level
- Providers should focus on clients with SPMI currently receiving CPST to assure a seamless transition
- Providers do not need to change the age group they serve (e.g. youth, adult) or populations (e.g. forensic, homeless) to become a health home
Is the health home service voluntary?

- Consistent with other Medicaid services, **client choice** will determine whether a client participates
  - The state cannot force a client into any service nor prevent them from participating
- Health home is a service delivery model **with multiple service components that may benefit each individual client depending on where they are in their recovery**
- State will send a high level communication but also encourage providers to educate SPMI clients and their families/caregivers
How does a health home interface with other services and/or programs?

- ICDS
- CPST
- DODD
  Targeted Case Management
- Treatment
  Foster Care
- ACT/IHBS
- Peer Support
- AoD Treatment Services
How do health homes interface with ICDS* for the Medicare & Medicaid Dual-Eligible Population?

- Payment for all services, including the Health Home, will be through the ICDS.
- Payment by the ICDS will be at the established fee-for-service rate.
- Consumers may receive care coordination through Health Homes for the life of the ICDS demonstration.
- Contract and other ICDS requirements and/or details are currently being developed.

* Integrated Care Delivery System
Can a client receive CPST from another provider while receiving health home services?

- **All CPST activities are now incorporated in the health home service and delivery model**
- **If a client is enrolled in a health home, activities formerly provided under CPST are included in the health home and are no longer separately reimbursable for that client**
  - In rare instances, when a client chooses to not participate in health homes, they can continue to receive CPST services
- **CPST can continue**
  - to be provided to clients who do not meet SPMI criteria
  - to be provided to clients with SPMI who choose to not participate in the health home via inclusion of a modifier code
- **State will track and monitor the use of CPST in these circumstances**
- **Current CPST limits will remain in place**
How do health home services interface with DODD targeted case management (TCM)?

- A developmental disability diagnosis without the presence of a SPMI diagnosis does not qualify a person for health home service.
- Targeted case manager authorizes DODD waiver services.
- Recommendation is that CBHC health home providers continue to work with DODD TCM providers to assure a client does not lose their TCM and therefore waiver services.
- Goal is to assure continuity of care and that the client’s needs are met.
Can children in foster care participate in a health home?

- Children in foster care can receive health home service if they meet the SED criteria and the client/parent/guardian chooses the service.

- ODMH encourages therapeutic foster care providers to assess whether or not they could potentially meet health home provider requirements.
How do health home services interface with ACT/IHBT in the future?

- Initial thinking was to establish two rates each for ACT and IHBT
  - ACT/IHBT rate for clients not receiving health home service
  - ACT/IHBT rate for clients receiving health home service
- Subsequent recommendation, based on feedback at the informational sessions, is that when a client no longer meets the IHBT or ACT eligibility criteria then the client will be transitioned to the health home team
- The state will continue to look at the relationship between ACT/IHBT and health homes as ACT/IHBT services and related Medicaid policies are being developed
How do health home services interface with Peer Support?

- There are several ways in which Peer Support can be included in the health home:
  - Peers can be included as a health home team member
    - Qualified Health Home Specialist
  - The service component descriptions include several activities that can be performed by peer support specialists
    - Individual and family support, health promotion
- The state will continue to look at the relationship between Peer Support and health homes as Peer Support services and related Medicaid policies are being developed
  - It will be important to distinguish how Peer Support is different from CPST
There are several ways in which AoD services and/or providers are included in the health home:

- Many CBHCs who are eligible to become health homes are also certified by ODADAS.
- The required health home team can include members with AoD treatment expertise.
- Health Home outcome requirements include the goal to Reduce Substance Abuse.
- Health Homes must coordinate care with all specialty providers, including those who are providing AoD treatment services.
- AoD treatment providers shall be part of the health home’s network of providers.
Q & A: Health Home Billing & Reimbursement
When and/or how often will the monthly case rate be reviewed/updated?

- Providers’ monthly case rates will be reviewed annually to determine whether or not it is necessary to rebase the case rate(s)
  - This review will be based on all providers’ actual costs for the prior year
- Cost based case rate methodology is in effect until sufficient baseline information is collected to determine a performance component for setting subsequent rates
- CMS must approve an approach to transition from the cost based methodology
Will the state reimburse for upfront start-up costs?

- No
- Administrative costs should be completed in accordance with ODMH UCR rules
Q & A: Health Home Regions
When will the health home regions be chosen?

- Significant interest and response to the ODMH request for LOI was received
- LOIs are being reviewed to determine local readiness
  - When CBHCs are fully able to meet requirements
  - Local capacity across providers to meet identified need within a region
- ODMH will announce the regions on or before July 1, 2012
• Care Manager Aide title has been revised to Qualified Health Home Specialist

• National Accreditation to demonstrate BH/PH integration will be required at the next scheduled survey
  ○ COA BH/PH accreditation is also acceptable
  ○ NCQA PCMH recognition or equivalent will still be required in 18 months as applicable
Other General updates

- Health home modes of service delivery may be
  - delivered to the beneficiary and may include other individuals who will assist in the beneficiary’s treatment;
  - be face-to-face, by telephone, and/or by video conferencing;
  - individual, family or group format; and
  - not site-specific and the health home services should be provided in locations and settings that meet the needs of the health home beneficiary.

- ODMH has released a draft certification rule as well as other rules which have been amended to support the inclusion of health homes in the ODMH standards
  - The rules will go through the normal public process and we have received comments through the clearance process which we will be reviewing.
Next steps

- **June**
  - Submit official SPA
  - ODMH will post rules for comments and file with JCARR
  - ODJFS will put rules into clearance and subsequently file with JCARR
  - ODMH/ODJFS will finalize business requirements for client utilization profile in conjunction with stakeholder feedback

- **July**
  - ODMH will announce regional implementation schedule
  - ODMH will post Provider Application
  - Providers in selected regions can begin to submit applications
  - ODMH will continue to work with advocacy organizations to engage their assistance to educate consumers, families and others
Next Steps, continued

- **August**
  - Providers will be notified of application status in initial regions
  - ODMH will work with providers on implementation details such as identifying consumers, training on how to report quality measures, sharing of the consumer utilization profile, etc.

- **September**
  - Identify clients participating in health home
  - Receive CMS approval for health home for SPMI

- **October**
  - State shares Client utilization profile
  - Submit claims to ODJFS for S0281
Where can additional resources be found?

- ODMH Health Home Website

- ODMH Health Homes mailbox
  - E-mail to: [healthhomes@mh.ohio.gov](mailto:healthhomes@mh.ohio.gov)
More Questions?